

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED JUN 5 1963

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Gardenville

Length of stay in 1b

1 month

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Miller Nursing Home

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

St. Louis

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

2336 Michigan

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

First

THERESA

Middle

Last

VOGEL

4. DATE OF DEATH

Month

May

Day

13

Year

1963

5. SEX

female

6. COLOR OR RACE

white

7. Married ☒ Never Married ☐

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

3/19/1879

9. AGE (last birthday)

84

10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)

at home

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (City and state or country)

Hungary

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Kovach

13b. MOTHER'S MAIDEN NAME

not known

14. NAME OF HUSBAND OR WIFE

Anton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

422.1

17. INFORMANT

Anton Vogel 2336 Michigan

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

myocarditis chronic

INTERVAL BETWEEN ONSET AND DEATH

unknown

DUE TO (b)

arteriosclerosis

unknown

DUE TO (c)

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Cerebral thrombosis

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 4-18-63 to 5-13-63 and last saw her alive on 5-11-63

Death occurred at 4 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

M. R. Walucki MD

22b. ADDRESS

8916 Summer

22c. DATE SIGNED

5-14-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial

23b. DATE

5/16/1963

23c. NAME OF CEMETERY OR CREMATORY

New St Marcus Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Mo.

24. FUNERAL DIRECTOR

ADDRESS

John L Ziegenhein & Sons 7027 Gravois

25. DATE RECD. BY LOCAL REG.

5-14-63

26. REGISTRAR'S SIGNATURE

John M. Murphy MD

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

1 4000

2 9/1/79

3

4 1

5 1

6

7 2

8 2

9 422.1

10

11

12 86-0

13

88

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

B. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graves's

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.